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ABSTRACT

Primary prevention refers to activities directed to high-risk groups, within a community not yet labeled as psychiatrically ill. These activities have the purpose of preventing the onset of emotional disturbance and enhancing the level of mental health. In general, whatever contributes to human stress in a community so that the individual or group is unable to cope can lead to poor psychological health and physical disorders and must be eliminated or reduced if health is to be promoted. The strategies for achieving the goals of primary prevention are two-fold: (1) strengthening individual competencies and/or descreasing individual vulnerabilities; and (2) promoting and strengthening community competencies and resources to modify or eliminate environmental and social stress. Groups frequently at risk in developing nations are women, migrants, and urban dwellers in a society undergoing industrialization. Their problems include illiteracy, lack of occupational skills, isolation, and inexperience with city life, problems which can cause a host of health problems. Prevention programs should be primarily educational and based on assessed needs of the targeted group. Planners need to seek the interest and cooperation of various community agencies for collaboration on formulating objectives, designing health promotion activities, and funding and implementing programs. Prevention programs are more likely to be successful when practitioners pool their resources with public as well as nongovernment organizations. (JB)

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Symposium Paper: Developing Innovative Strategies for Primary Prevention in the Third World

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A preventive psychology attempts to prevent psychological and physical disorders and promote health and well-being.

Primary prevention has two main objectives:

(1) to reduce new incidences of psychopathology before they occur, and

(2) to promote mental health.

Stephen Goldston (1977) has provided the following operational definition:

"Primary prevention encompasses those activities directed to specifically identified vulnerable high-risk groups within the community who have not been labeled as psychiatrically ill and for whom measures can be undertaken to avoid the onset of emotional disturbance and/or enhance their level of positive mental health. Programs for the promotion of mental health are primarily educational rather than clinical in conception and operation with their ultimate goal being to increase people's capacities for dealing with crises and for taking steps to improve their own lives".

A puzzling question is confronted immediately: "How can one carry out primary prevention programs to accomplish the objectives of primary prevention when the target population have no symptoms of mental disease which can be observed or when the person is not aware or has not reported any serious psychological distress"? However, there is a large body of research literature in the West that tell us where to look and what indirectly cause or contribute to psychological and physical disorders. For example, the No. 1 killer in western countries, cardiovascular or heart disease, is most common among people with a long history of poor health habits (heavy smoking and drinking, a high fat

diet, low physical activity) and poor coping abilities with the stresses of living. Presently healthy populations who ignore these correlational factors in their lifestyles are at high risk of suffering from poor health and terminal illnesses in the future.

Western psychologists have learned to shift their focus from looking at etiology of disorders from a person-centred approach to a broader environmental and ecological approach. Traditional psychology, with its total emphasis on the roots and causes of psychopathology as residing within the person, have proven inadequate. Health promotion cannot be understood simply from a conceptual framework of personal dynamics or even organic syndromes or biochemical imbalances. Promotion of health and well-being needs to be a preventive psychology focused on the entire community to which people belong. The quality of life in a community, from nutrition, housing, education, to family life and social conditions are all significant macro-factors. In general, whatever that contributes to over-whelming human stress in the community so that the individual or group is unable to cope with these stressors, can lead to poor psychological health and physical disorders and have to be eliminated or reduced if we want to promote health.

How can the goals of primary prevention be accomplished? The strategies are two-fold:

(1) strengthening individual competencies (personal, interpersonal, and impersonal) and/or decreasing individual vulnerabilities, and

(2) promoting and strengthening community competencies and resources to modify or eliminate environmental and social stress.

These strategies are based on a framework using a psycho-socio-cultural-educational approach. Counseling, mental health consultation, community organization, training, mental health education and community development are some of the major forms of prevention activities.

Over the past decade prevention research and programs have demonstrated and generated workable tools and technologies, scientific findings and experience which can be used to achieve the goals of primary prevention. Let me now focus on potential prevention programs for target populations relevant to third world countries. Population Census in Thailand indicated that the female illiteracy rate is roughly twice that of men. About 50% of working women, especially those aged over 20 years were estimated to be illiterate or semi-illiterate, placing the figure in 1980 at 15 million women. The negative consequences of such functional incompetency is obvious, i.e., illiterate women have poorer knowledge of child care and services, lack necessary information to solve their own problems, have greater difficulties in obtaining decent jobs, etc. Such a vulnerable group is highly susceptible to a host of health problems.

Prevention efforts for this group would call for raising female equality by reducing the burden of female illiteracy. Specific adult education programs, both formal and non-formal, can be aimed at different target groups of women: urban women, rural women, working women, etc. depending on their specific needs and the types of skills lacking. Prevention programs for migrant women workers are worthy of future discussion because they are part of the large influx of rural workers moving into large urban cities in many developing countries.

The migrant is a high risk group because of his/her inexperience with city life, illiteracy and lack of occupational skills with few personal or material resources. Emotional factors compound the difficulties of adaptation: isolation, loneliness, seperation from family and friends, fears and worries of unemployment, or losing their employment. These multiple factors predispose migrant workers to poor health and illness. It explains why the prevalence of psychiatric disorders and somatic illnesses appear to be 2-3 times higher among recent migrants as among the local population.

It is easy to generate a long list of program objectives for migrant workers, both male and female:

(1) Needs assessment research which includes directly consulting target members on their needs and priorities rather than depending solely on official sources.

(2) Delivery of a variety of educational programs such as literacy programs, and vocational training, life skills programs for financial, legal, employment, health care, counselling needs as well as social support networking. The long term goals are to improve the migrant's access to health, educational, social and employment resources.

Regardless of the nature of each program, planners would need to seek the interest and cooperation of various community agencies and groups to collaborate on all aspects of the programs to formulate objectives, to design health promotion activities, on program delivery, implementation and funding. Prevention programs are more likely to be successful when practitioners link and pool their resources with public

as well as non-government organizations.

Our discussion of health promotion strategies in third world countries directed at large populations in capital cities such as Jakarta will be more complete by targeting on all workers. Like other developing countries, the goal of achieving higher standards of living through an industrialized economy mean that Indonesian workers must adapt to changes in working and living conditions resulting from industrialization and mechanization. Much can be learned from developed countries with their earlier experiences on industrialization and automation in relation to preventing occupational ill-health.

In the industrial workplace of Western nations, control of physical health hazards for the safety of workers have long been regulated by government agencies. In addition, occupational hazards springing from psychosocial factors generating chronic stress is fast being recognized as a major significant contributor of ill-health among urban populations. On the other hand, very little has been studied about occupational factors and their health effects in third world countries. However, several relevant comments can be made:

1. A worker's socio-economic class (SES) is directly linked to his/her susceptibility to illness and state of health. For example, a low educational background adversely effects workers reaction and ability to cope with industrialization changes, and countries with low literacy rates are even more adversely effected.

2. Economic and cultural factors also influence workers reactions to stress and coping patterns. Under conditions of high unemployment, for instance, workers experience greater risks by taking jobs that are

high-stress or associated with unfavourable working conditions. In short, a combination of negative factors in the work environment such as:

Low SES + Poor economic conditions + Physical hazards = creates a high risk population susceptible to poor health and disease. Workers who are distressed, dissatisfied and unmotivated become sick workers and sick people become less productive with detrimental effects for employers: high absenteesism, labour turnover and inefficiency.

Yet, while work can impair health, we are all aware work also contributes positively to our health. Work is a crucial aspect of a productive life and necessary to our social, emotional and physical well-being. According to the World Health Organization's definition of health, it is not merely the absence of disease but also a state of physical, mental and social well-being. To promote health then we have to promote a positive work environment or psychosocial atmosphere. As emphasized earlier, primary prevention efforts are needed rather than waiting for sick workers to appear for referral to medical/psychiatric facilities for treatment and rehabilitation.

An obvious first step is to conduct systematic research of culturally relevant factors contributing to psychosocial health. For example, what factors contribute to the apparent lower absenteeism in smaller factories and establishments and what cultural traditions contribute to work satisfaction, such as the setting up of mosques and religious facilities on factory premises? Another question concerns the issue of the control of adverse stress factors. How can health services be expanded beyond simply treatment of illnesses? In the workplace,

what can be done to assess and monitor the work environment and health status of workers? Some program possibilities are:

- assessing existence of psychosocial stress factors in workplaces
- detection of behavioural changes in workers suspected of leading to ill-health
- development of action plans to prevent their occurrence
- co-ordination with management, workers and health practitioners to design, implement and evaluate prevention services and health care.

Lastly, I wish to focus on ourselves as health practitioners, administrators and researchers in industry, government and academic institutions. This is where we must begin to communicate with one another to spark interest, seek cooperation and formulate strategies and priorities to actualize the goals of primary prevention. Some suggested means are:

1. develop new curriculum and graduate programs in academic institutions in prevention training stressing community research and practice.
2. collaborate with faculty members from various academic disciplines and with other universities both locally and abroad, and
3. seek funding for prevention research, faculty and student training and exchanges from international aid agencies. United Nations agencies and agencies such as C.I.D.A. and I.D.R.C. in Canada can be approached for funding. Given some consensus on primary prevention as one major national priority to raise the nation's health, program proposals that are well articulated should receive financial support from international development agencies.